Professionals' perspectives towards health promotion in residential aged care: an explorative study in Austria

Article (Accepted Version)

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Published in: Health Promotion International, 2016 (advance access), doi: 10.1093/heapro/daw075

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Acknowledgments: The authors would like to thank the professionals for being positive and willing to participate in the study. Thanks to Hermann Schmied for supporting us in the recruitment of interviewees.

Abstract

Following the trend in most developed countries, in Austria the oldest old are the fastest growing population group. Among this group, there is a high prevalence of multimorbidity, functional impairment, dementia, and psychiatric conditions. While health promotion (HP) has been considered relevant in coping with the challenges of an aging population, it has so far been viewed as a foreign concept in relation to the oldest old, especially those living in residential aged care (RAC) facilities. Although there is an acknowledgement that HP should be integrated into routine nursing, there has been little research on how professionals working in RAC interpret and implement HP. In this study, thirteen semi-structured interviews were carried out with professionals from four major Austrian RAC providers. Data was analyzed using thematic analysis. The findings show that, typically, professionals understand HP as a concept that is oriented towards maintaining potentials and resources, thereby promoting self-determination, autonomy, and social integration, including frail and functionally impaired elderly residents. However, data analysis also revealed a gap between the conceptual understanding and positive attitudes towards HP and its implementation in practice. Implementation of HP seems to occur in isolated cases, related to specific health issues. It seems that more complex HP approaches, especially the 'settings approach', are hardly practiced. To implement more comprehensive and systematic HP in Austrian RAC, support from external HP agencies as well as changes in financial incentives are needed.

Keywords

Health Promotion / Old Age / Residential Care / Concepts of Health Promotion

Introduction

As a consequence of low fertility rates combined with longer life expectancy, the proportion of older people is increasing in the European Union (EU) (Rechel *et al*., 2013). In particular, the oldest old (people aged eight-five and over) are the fastest-growing population group (European Commission – DG Economics and Financial Affairs, 2011). In Austria, the proportion of the population aged eighty-five or over almost doubled during the last two decades from 1.3 per cent in 1990 to 2.4 per cent in 2013 (Eurostat, online data code: demo_pjangroup). Among this group, there is a high prevalence of multimorbidity, functional impairment, frailty, dementia, and psychiatric conditions (Marengoni *et al.*, 2011).

Health promotion (HP) has been considered relevant by European policy makers to successfully cope with aging populations and respective health problems and thus has become an integral part of the healthy and active aging policy (WHO, 2002; Oxley, 2009; European Union Committee of the Regions, 2011). According to the Ottawa Charter for Health Promotion, HP is emphasized as a process of "enabling people to increase control over and to improve their health" (WHO, 1986, p. 1). Health, in this context, is defined as a positive (resource-oriented) concept rather than a negative (disease-oriented) concept, and it is recognized that health is multidimensional and influenced by factors outside a person's control. The focus of respective HP interventions therefore lies on empowerment of individuals and communities. Building on the Ottawa Charter's definition of HP active aging is understood as a process of optimizing the potentials for maintaining health, social participation, and security with the aim of promoting the quality of life of the elderly (WHO, 2002). In this sense, several HP initiatives and programs directed at the elderly have been developed within the EU (Oxley, 2009; European Union Committee of the Regions, 2011).

Although more and more HP initiatives addressing aged populations can be found, it is striking that the group of the oldest old has been rarely considered. While schools, hospitals,

and work places are among the more established settings for HP (for an overview see: Poland *et al*., 2000), often united in international networks, residential aged care (RAC) facilities have been rarely addressed by comprehensive HP initiatives (Krajic *et al*., 2015). HP for the oldest old within RAC facilities has been considered challenging, both in terms of typical organizational structures and processes (e.g. staff shortage, lack of training, etc.), but also concerning the health status (multimorbidity, frailty, dementia, etc.) of its users (Horn *et al*., 2011; Marent *et al*., 2014).

Nevertheless, current review articles indicate clear evidence that HP can improve the functional health, autonomy, and quality of life for the oldest old (Minkler *et al*., 2000; Resnick, 2003; Prohaska *et al*., 2006). These reviews highlight positive effects of various types of HP interventions such as physical activity, nutrition and changes in the physical and social environment. Particularly for physical activity interventions recent studies show that these have positive effects for people in old age by improving aerobic power, strength, flexibility, occupational performance (Chin *et al.*, 2008; Stathi and Simey, 2007; Weening-Dijksterhuis *et al.*, 2011) and increasing subjective health status (Cichocki *et al.*, 2015). Therefore, several authors suggest that HP for this group must be paid more attention (Minkler, 2000; Harris *et al*., 2008).

On the other hand, several studies indicate that, although HP is increasingly acknowledged to be important to nursing, it is not systematically translated into practice (Casey, 2007; Flick *et al.*, 2004; Johansson *et al.*, 2009; Horn *et al.*, 2011; Kemppainen *et al.*, 2012; Kelly and Abraham, 2007; Wills, 2014). It is also striking that most of the studies exploring nurses' attitudes, concepts, and practices of HP have been conducted in primary care (Johansson *et al.*, 2009; Flick *et al.*, 2004), hospitals (Johansson *et al.*, 2009; Kelly and Abraham, 2007), even in acute surgical and emergency departments (Casey, 2007), whereas the RAC setting has been hardly addressed at all (Horn *et al.*, 2011).

In principle, Austria offers favorable conditions for the implementation of HP in RAC because HP has been acknowledged as an official task of the nursing profession since the new Nursing Act was passed in parliament in 1997. The Act states that nursing education and practice have to include actions to maintain and promote health on physical, mental, and social dimensions, acknowledge the specific life situations of users (read: residents of RAC facilities), and thus support their autonomy and self-determination.

The question how this formal support for HP is translated into practice and how HP can be strengthened within Austrian RAC facilities has been an integral part of the scientific program of the Ludwig Boltzmann Institute Health Promotion Research (LBIHPR) in Vienna. Since 2011, the institute closely collaborated with one large provider of RAC to develop and implement the pilot project 'Health has no age' that emphasized a whole-settings approach to reorient RAC facilities towards HP (Krajic *et al.*, 2015). This project was based on a multidimensional understanding of health, addressed multiple target groups (residents, relatives, staff, etc.), and applied multiple strategies to develop a health-promoting environment. The project outcomes and follow-up studies revealed the role of professionals as powerful agents within any efforts to re-orientate RAC towards HP (Krajic *et al.*, 2015; Marent *et al.*, 2014). An understanding of RAC facilities as 'professional organizations' (Wieczorek *et al.*, 2015) lays emphasis on the autonomy of professionals in the extent to which they engage in HP and implement it within their work routines with users. To implement HP beyond formal structures (e.g. policies and guidelines) and to ensure that it becomes part of the organizational behavior (e.g. professional-client interaction) it is crucial that professionals are willing and competent to engage in HP. As starting point for investigating how HP in RAC in Austria can be strengthened and implemented beyond the pilot project and within other providers, this article explores professionals' concept of HP, their perception of its relevance and practices in relation to HP.

To investigate various dimensions of HP integration within professional practice, this article draws on a theoretical model proposed by Pelikan (2007). The model combines two theoretical propositions: First, that practice is a function of the 'field' that consists of both the individual and its environment (Lewin, 1964), and, second, that the selection of a specific practice is based on both capability and motivation (Coleman, 1994). Through the combination of these two propositions, four determinants for the formation of HP practice can be deviated: capability and motivation of an individual as well as resources and symbolic support in the environment.

From this theoretical model we deviate three research questions:

1. What is the specific concept of HP for residents in RAC held by professionals?
2. How do professionals perceive the relevance of HP for residents in RAC?
3. What practices do they apply related to HP for residents in RAC? And which supportive resources or barriers do they perceive?

By exploring the concept, the perceived relevance, as well as resources and barriers that currently shape HP practices of Austrian professionals, this article aims to contribute to discussions of options and challenges for a more systematic implementation of HP in the RAC setting.

Method

Study design

For the purpose of this study we chose a qualitative approach based on semi-structured interviews. This method of data collection is well-suited for exploring individuals' views and experiences of concrete phenomena as well as abstract concepts (Ritchie and Lewis, 2009). Therefore, the way in which professionals describe HP as part of their practice can be explored.

Study setting

In Austria, like in most European countries, RAC involves facilities where users reside permanently, are offered shelter and elderly care due to increased dependency, and are seventy-five years old or older. In 2007 the RAC sector in Austria consisted of 70.107 places for residents, which covers about 18 % of the population that has a certified need of care and receives 'care benefits'. The remaining 82% are supported by mobile home care services (25.6 %), a rooming in model providing '24-hours home care' (5.1 %), and informal care, primarily provided by family (51.3 %) (Krajic *et al.*, 2010). Governance of the sector is considered problematic; due to fragmented political responsibility and a political, financial, and institutional separation between the health care and the social care sector with aged care belonging to the latter.

The study presented in this article took place in one province of Austria and involved employees of the four largest providers of RAC (two public, two private) in this particular province. These providers offer residential care, ranging from forms of supported living up to intense and specialized forms of care in nursing units.

Study participants and recruitment

The selection of study participants within each provider was based on purposeful sampling (Ritchie and Lewis, 2009): based on consultations with experts, both in the field of practice and in research related to RAC, we included thirteen professionals. Our intention was to recruit participants that (a) worked for different providers, (b) had a professional background in either nursing or business administration, and (c) included both men and women. The group of interviewees included ten women and three men who held either top-management or middle management positions. The selection of participants holding a management position

was informed by findings of a previous study (Marent *et al.*, 2014) that revealed the significant role of managers for providing resources and symbolic support to implement health promotion in RAC. For a detailed overview of the participants' profiles see Table 1. For this study, the aim was not to compare professionals with different background or from different providers but to capture the range of experiences. Therefore, we do not consider the over-representation of professionals with a nursing background as problematic. To ensure confidentiality, all participants were assigned pseudonyms, e.g. P1. Each participant was invited to an interview and informed of the content as well as the purpose of our study via mail by the lead author. All the people contacted were willing to participate in the study. They were individually phoned by the lead author and a date and time for the interview was arranged.

Insert Table 1 here.

Data collection

Between May and July 2013, thirteen individual, semi-structured interviews were carried out. Interviews took place in the facility where the particular interviewee was working and lasted on average fifty minutes. During the interview, we used an interview guide that provided narrative stimuli and also ensured that the research questions were covered. Questions asked included:

-How would you describe the meaning of HP in the context of RAC?

-How would you assess the relevance of providing HP for elderly residents?

-In your organization, how is health promotion integrated and practiced?

The interview guide was used as a memory aid and was not meant to strictly structure the interview to a certain order. All interviews were digitally recorded and afterwards transcribed verbatim. Interview sections that are used within this article as quotations were translated

from German to English by the authors of this paper and cross-checked with a colleague who has been responsible for official translations in the past.

Data analysis

Data was analyzed using thematic analysis (Ritchie and Lewis, 2009). To become familiar with the data, transcriptions were read through several times by BM and CCW. A coding scheme was mutually developed within the research group based on deductive and inductive approaches: Identification and labeling of codes followed the main themes of our interview guide that are consistent with the research questions (deductive). Within these themes further codes were constructed by sub-themes that emerged through multiple readings and interpretation of the data (inductive). Codes that were not relevant to answer the research questions were not further analyzed (as part of the research conducted for this article). Data analysis comprised an iterative process: First, coding was done sequentially (line by line, transcript by transcript) and, in further steps, analytic work focused on specific sub-themes and interpretation was performed on specific paragraphs. The actual coding of the data was performed by BM. To enhance the rigor of data analysis, CCW also coded some of the transcripts and all coding was weekly discussed and negotiated between BM and CCW. Both researchers were involved in data collection and thus the analysts were aware of the respondents' identities. Following the initial review, the whole group of researchers (BM, CCW, KK) worked together in a series of meetings over a period of six months to refine the coding scheme and to reach consensus on the ultimate interpretation of the data. Within the data analysis no HP theory was used, rather we aimed to elicit what professionals described and practiced as HP. Atlas.ti software was used to support the management of the textual data and to organize the codes being assigned to the transcript data.

Ethical considerations

Before the interviews started, all participants were informed that participation was voluntary and that their confidentiality would be secured at all stages of the research process. Prior to commencement of the interview, participants orally confirmed to take part in the study and that we could digitally record the interview. They were also informed that stopping the interview would be possible at any time. The local ethics committee approved the study in advance (EK 13-188-VK_NZ).

Results

Following the three research questions, the findings are divided into three main themes: (1) professionals' concept of HP, (2) professionals' perceived relevance of HP, and (3) HP in practice. Within the material, associations between the themes become evident since the concept of HP influences its perceived relevance and the way in which it is translated into practice.

1 Professionals' concept of health promotion

In the analysis of the professionals' views on the concept of HP, two sub-themes emerged, which are strongly related to each other: "*It's about avoiding merely seeing deficits*" and "Promoting self-determination, autonomy and social integration as central aims of health promoting aged care".

"It's about avoiding merely seeing deficits"

Typically, participants described HP as a concept that is clearly orientated towards potentials and resources. They considered the maintenance of these potentials and resources as the core of their HP work with elderly residents. As one such professional stated: "…what we don't want and don't do is to care our residents 'into' the wheelchair" (P1). As illustrated in this

quotation, a number of professionals explained that the process of care implies the risk of taking away all responsibilities, efforts, and tasks from the residents: a deterioration of residents' potentials and resources. The consequence of such a process was anticipated by the professional with the metaphor "to care our residents 'into' the wheelchair". Professionals were aware that health resources can be maintained and increased through their usage (they are generative). If people were not given opportunities to use their own health resources, participants assumed that they might decline.

The interviewees further put emphasis on a resource-oriented concept of HP and clearly demarcated it from a deficit-oriented approach. Multiple professionals explained that HP made nursing more attentive, that health rather than disease or frailty underpinned their work. One interviewee explicated that HP makes nurses sensitive to primarily assessing the resources of the frail elderly and to question how these resources could be strengthened to compensate for physical (or other) constraints: "It's about avoiding merely seeing deficits; it's rather a physical weakness which can be compensated for by strengthening other parts of the body" (P2).

While most professionals made a distinction between HP and disease prevention (by emphasizing that the former focuses on health, potentials and resources), one interviewee argued that this distinction does not make any difference in practice. She reported on a prevalence study taking place in the RAC facility where she was working and which assessed risk factors and diseases among residents. Concerning this study, she remarked: "… however, tackling these problems [risk factors and diseases] can also be seen as an endeavor to promote a healthy diet or to prevent malnutrition" (P3). This quotation reveals that from the perspective of this professional, risk factors and diseases can be starting points for HP. Therefore, the usefulness of a strict distinction was questioned and practices of risk prevention and prophylaxis were considered as part of, or a synonym of, HP.

Promoting self-determination, autonomy, and social integration as central aims of health promoting aged care

While acknowledging the aims of HP for residents, many interviewees mentioned self-determination as a central aspect. Self-determination of elderly residents means that they are largely allowed to determine the course of their everyday life, as the following example shows: “If he wants, he can have breakfast wearing his dressing gown. … And he can take a shower even in the evening because he wants it … people are living here … it’s their home … and, therefore they can walk around as they like” (P7). In relation to self-determination, some interviewees further emphasized that residents are not “over-protected” by staff. They pointed out that residents should be able to use free spaces which support their quality of life instead of staff constantly avoiding all possible risks. In this way, one study participant explained that she continuously tries to make her staff feel secure so that they can, for example, allow residents to go on the balcony by themselves.

Another important aim of HP emerging from the professionals’ accounts referred to autonomy. The function of HP was seen as enabling elderly residents to arrange daily activities and tasks (e.g. dressing or going for a walk) by themselves. In relation to autonomy, most interviewees particularly emphasized the training of physical activities (these activities will be further described in theme 3).

Another important aspect was social integration. Several professionals mentioned that HP aims to support social integration among the elderly. Thereby the importance of social contacts and participation in social life such as culture and leisure time activities were emphasized to contribute to health and well-being of the residents. Study participants illustrated the way in which social integration can be facilitated by several activities that will be further emphasized below (theme 3). In the following, only one example from a professional referring to a birthday party where an opera singer has been invited to sing together with residents is mentioned: Concluding his narration about the birthday party, the

interviewee stated, "… that was amazing. You see residents participating in 'real life', that's amazing and I think for me, that's health promotion" (P8). In line with this statement, some professionals felt that such "highlights" (e.g. the mentioned birthday party) were very much needed by elderly residents, as such events could enrich and give meaning to life in RAC.

2 Professionals' perceived relevance of health promotion

While analyzing professionals' perceived relevance of HP, two separate sub-themes could be identified. First, "Maintaining the quality of life" reveals how professionals appraised the value of HP. Second, "Health promotion as an integral part of the professionals' role" discusses in which ways professionals considered HP as part of their jurisdiction.

Maintaining the quality of life

Only a few skeptical attitudes towards HP for the elderly were found in the data. Two of our interviewees argued that HP has to be accomplished in earlier life phases. In old age, they stated, no health resources were left and health behaviors might not be changeable as they are fixed in routines: "There is not much need to provide extensive health promotion for an old person. Because: What do you want to change? This person can't change anymore, and I think they are all so frail, it [HP] should be delivered in earlier life phases" (P6).

The trend, however, was for professionals to express positive attitudes towards HP in RAC. In terms of possible outcomes of HP, these professionals were doubtful about whether health could be increased in old age. Rather, HP was considered relevant to maintain health resources and to support quality of life: "Health promotion rather aims to maintain quality of life. I'm not sure whether you can enhance it, but at least you can maintain it" (P3).

Moreover, the data analysis revealed advantages of HP not merely for residents themselves. Interviewees also felt that HP for residents had advantages for staff working directly with them. Participants believed that HP activities could ease several work tasks,

enrich organizational everyday life and, thus, enhance work pleasure: "… the longer a resident is active, the more enjoyable it is for myself … living together is more pleasurable when residents are active" (P4). As the quotation illustrates, participants paid particular attention to the positive effects of residents' activity level. They assumed that the atmosphere within a RAC facility becomes more agreeable if residents are more active.

Health promotion as an integral part of the professionals' role

Our interviewees, when asked about how they perceived their role with regard to HP, drew a fairly differentiated picture. They pointed out that by law, HP is part of the jurisdiction and job description of nurses: "Per se, it's a health and nursing care act. In it, health promotion is described as a task of the nursing profession. Thus, it [HP] is statutory. But this is only the formal side. The other side is how it's enacted in daily life" (P4). As this interviewee indicated, the formal integration of HP in the job description of nurses does not determine how HP is practiced in the daily work of RAC facilities. Several participants emphasized that within practices of front-line staff, HP is not yet explicitly a topic. Interviewees even felt that front-line staff, until now, does not perceive their own work tasks as being "health promoting". In this way, one interviewee mentioned: "I think, many things have to be done more consciously … it's about raising awareness among staff that the things they're doing are health promotion… We do health promotion but unconsciously, it's not conscious yet" (P8). This statement revealed an inclusive understanding of HP. However, it also highlighted that HP lacks the attention and support of the front-line staff in RAC facilities. Our interviewees believed that it was one of their duties to make front-line staff aware of and familiar with HP. In this sense, most study participants emphasized the HP potential of nurses' ordinary work, and argued that several aspects of existing caring activities could be considered as health promoting.

3 Health promotion in practice

In relation to the practices of HP, two sub-themes emerged within the data. On the one hand, professionals delineated what kind of HP activities are offered to elderly residents. On the other hand, they mentioned factors that either enable or impede HP practices within RAC.

The spectrum of health promotion activities for the elderly

In relation to professional practices of HP, we identified four key areas in our data: promoting physical activity, nutrition, psycho-social well-being, and the development of adequate care. These activities, as will be indicated, are related to professionals' conceptual understanding of HP (theme 1).

All professionals referred to physical mobility as a major part of HP practice in RAC. Physical mobility was often promoted in relationship with daily activities. Thereby, professionals instruct and do exercises with individual residents in order for them to accomplish specific everyday challenges independently (e.g. climbing stairs, taking a shower). Moreover, specific group programs were mentioned which focused on residents' strength and balance. Some professionals further indicated that physical mobility training can also contribute to fall prevention, as the following statement illustrates: "We make sure that residents stay autonomous, that they do exercise and move because then they have more stability and, of course, falls can be prevented" (P6). This quotation reveals that physical activity is considered as a means to promote autonomy of individuals, which has been identified as a central aim of HP by professionals (see theme 1).

Another important area for HP was nutrition. Many professionals indicated malnutrition as a considerable challenge for HP in RAC. Accordingly, measures such as screening the food habits of residents and respective counseling programs were implemented. To promote healthy nutrition, according to our data, healthy meals (e.g. vegetarian options) were offered and some facilities even had their own kitchen where meals were freshly

prepared. Promoting healthy nutrition is illustrated in the following statement: "… for several years now, we have the 'healthy dish' option which offers fresh, seasonal, regional food all year long. In our facility, residents were even educated and motivated to try out this dish" (P11).

With regard to psychosocial well-being, study participants mainly emphasized the importance of social relationships and social integration (discussed above in theme 1). These are promoted by regular events and celebrations (e.g. singing and dancing groups or birthday parties) where residents can find the opportunity to make new friends. Several professionals pointed to the importance of social relationships beyond the RAC facility: "Volunteers or civil servants, everybody from outside is relevant, impressions from outside are very important" (P5). These professionals argued that volunteers make important contributions to the psychosocial well-being of residents by visiting and spending time with residents, entertaining them (e.g. playing chess, reading the newspaper out loud), or supporting them during excursions.

Data further revealed an understanding of HP as a component of all caring processes, a finding that has already been indicated above (theme 2). Therefore, the provision of an adequate and high quality system of care was indicated as part of HP practice within RAC facilities. In this way, professionals pointed out the health-promoting potentials of various caring approaches, in particular patient-centered approaches that include biographical work: "A central aspect of our work is good biographical work to really get a feeling for the resident's wishes and needs, what he has done in his life. If we have all this information, we can consider it during the preparation of care services, in all care assessments, the whole case history" (P1). As the quotation indicates, knowing what has been important for the resident in the past should be considered within the current provision of care. Interviewees felt that care should become adapted to residents' specific needs. Thereby, the comfort and quality of life of residents should be guaranteed.

Enabling and impeding factors for health promotion implementation

Several factors were identified by professionals that enable or impede the implementation of HP practice in RAC. Many professionals highlighted the importance of leadership in order to achieve successful implementation: "Health promotion has to be a strategic priority, it has to be desired, it really needs… a decision by the top-management that we are going to do it [HP]" (P12). Our interviewees perceived that, as managers, they should stimulate readiness and motivation for HP as well as making it an organizational priority (e.g. by issuing HP policies). Yet, participants were also aware that beside this symbolic support, putting specific structures and resources into place is a considerable prerequisite. As such, resources for advanced training of staff and time frames for collaboration and exchange (e.g. learning groups) were named as facilitators of HP practices. However, specific examples of structures and processes, as well as how they had changed these, did not appear in the data.

Furthermore, the education, skills, and attitudes of staff were considered as crucial factors to facilitate implementation of HP. Some professionals stated that academic education contributes to effective HP practice. They believed that academic educated staff is more likely to reflect on residents' health resources and is better skilled than front-line staff without academic degrees. With regard to the latter, one professional argued: "They lack basic requirements, they lack a certain educational level to ask such questions [questions concerning HP]" (P3). However, it was also stated that lower educated staff can be acquainted with HP through specific training programs.

Several professionals also indicated that implementation is often impeded because of current changes occurring in the RAC sector. Here, interviewees referred to changes in staff and residential structures, new financing models etc. As a consequence, many RAC facilities were not in routine operation and staff was still engaged in familiarizing itself with new organizational processes. These change processes were perceived as impeding HP practices.

Several professionals mentioned that before HP programs can become readily implemented, functioning organizational routines are required.

Residents' health conditions were perceived as another barrier for HP by some professionals. For example, in the case of multimorbid persons, controlling symptoms and diseases was regarded a priority compared to HP: "…residents require more and more care because they are becoming increasingly multimorbid etc. Nowadays, during three months of resident stay, their condition often worsens considerably. As a consequence, a lot of time is invested in tackling certain symptoms and diseases and therefore it [HP] is not a significant topic" (P3). Apart from residents' health condition, implementation was also hampered because of residents' lack of motivation to participate in HP activities. Many professionals mentioned that particularly those residents who were most in need of HP refused to take part in related programs and activities: "…those who need it [HP] to not deteriorate, those are really difficult to convince" (P10).

Discussion

In this study, we found rather congruent descriptions of the concept of HP among professionals in Austria. Professionals clearly emphasized resource-oriented and salutogenic aspects of HP. Having this concept of HP, professionals were able to demarcate HP from disease prevention. These findings deviate from the results of a previous study conducted in German RAC facilities (Horn *et al*., 2011). The authors highlighted that professionals held vague concepts of HP and were not able to distinguish it from prevention. Moreover, our results differ from more general studies on HP within health service delivery. In contrast to our study, those studies conclude that the concept of HP is often used extensively and its broad interpretation contributes to confusion among professionals (Johansson *et al*., 2009; Casey, 2007; Flick *et al*., 2004). A possible explanation for the profound conceptual

understanding of HP found in our case is the formal integration of HP within the Nursing Act as outlined in the introduction. This Act may have led to a stronger examination of HP among professionals working in the RAC sector.

Nevertheless, the understanding of HP by our participants also showed that they had a rather individual-focused perspective of HP. Professionals primarily emphasized efforts to support residents in accomplishing daily activities, to train their physical mobility, or to counsel them on healthy nutrition. However, hardly any comments could be found where professionals described efforts to change the spatial or infrastructural aspects of the environment within RAC facilities to enable residents to realize their health needs or lobby for supportive legal and financial environments. Thus, our interviewees seem to follow a rather behavioral approach towards HP and to neglect an ecological approach. Following Poland *et al*. (2000), an ecological understanding of HP would emphasize changes within the organizational setting of RAC. This could involve efforts to encourage residents to engage in decision-making (e.g. by access to a residents' council) or a broader definition of the target groups for HP that goes beyond the individual resident and also encompasses his or her relatives. Yet, focusing on residents' behavior corresponds with the findings of a systematic literature study by Kemppainen *et al*. (2012). They identified a perspective with the focus on the individual as the most common factor influencing the concept of HP among nurses working in various health care settings. In this sense, nurses referred to giving information to and supporting their patients, when describing their HP activities.

Beside the resource-oriented concept of HP, the majority of our professionals was aware of the importance of HP and perceived it as part of their role. The meaningfulness and value of the maintenance of health among the elderly living in RAC facilities were considered unquestionable by most interviewees. Positive attitudes and the willingness to provide HP for people aged over sixty-five have also been found in a UK study among hospital nurses and health care assistants (Kelly and Abraham, 2007). Our study also confirms findings

highlighted within the broader HP literature, which shows that HP is becoming increasingly important to the nursing profession (De Leeuw, 2009; Wills, 2014). Correspondingly, Whitehead (2005) indicates that nursing, as the largest health profession workforce, is in the best position to spread HP in health care practice.

However, our data indicated a gap between the conceptual understanding and the perceived relevance of HP on the one hand, and its implementation in practice on the other hand. While professionals were able to describe the conceptual underpinnings of HP and its relevance, they had difficulties illustrating the implications of HP for practice as well as for their particular role in enabling implementation. Although study participants mentioned several HP activities e.g. strengthening or maintaining physical mobility or psychosocial well-being, these activities were often provided as single programs. Implementation of HP occurred in relative isolation and mostly related to particular issues, e.g. the particular health needs of individual residents. Using Johnson's and Baum's (2001) typology, this approach of HP implementation can be indicated as 'doing a health promotion project'. This means that the RAC facilities were not challenged to develop its structures, processes, and roles towards HP, but HP rather occurs in opportunistic ad hoc events. The application of such an approach has been criticized for its lack of sustainability and integration, and has been situated on the bottom of the continuum of HP approaches towards 'being a health promoting setting and improving the health of the community' (Johnson and Baum, 2001). To be a health promoting setting, multiple and coordinated initiatives are required to embed HP within the culture and routine processes of the organization that ensure that health is a priority within the entire organization and its wider environment or community (Johnson and Baum, 2001; Poland *et al.*, 2000). While the settings approach is advocated as the best way to re-orient organizations towards HP and to ensure sustainable and holistic health improvement (Johnson and Baum, 2001; Poland *et al.*, 2000), the RAC facilities investigated in this study lag far behind in its realization.

Thus, how are difficulties in implementing comprehensive HP in RAC to be explained against the background of professionals' thorough conceptual understanding? According to previous studies in Austrian and German RAC settings, adequate organizational capacities and resources lack comprehensive HP implementation (Krajic *et al*., 2010; Horn *et al*., 2011; Marent *et al*., 2014). Due to demographic change and the corresponding increasing demands for RAC, these facilities are challenged by increasing workloads, increasing health strains on staff and only slowly improving financial resources. Yet, few professionals interviewed for this study have mentioned the constraints of their situation as a major obstacle to implementing a more comprehensive HP approach. Rather than questioning the restrictive nature and the lack of resources within their sphere of activities, the professionals seem to attempt to pursue HP in the limited ways available to them.

Methodological considerations

One strength of this study is that it involved a wide range of aged care professionals with a background mainly in nursing, but also in business administration, and from different providers. The qualitative approach provided valuable insights into professionals' conceptual understanding and practices of HP. However, the study was limited to one province of Austria and participation was voluntary. We have to assume that only professionals more interested and competent in HP have participated. Moreover, only aged care professionals in a management position were interviewed for this study. Therefore, further research on how front-line practitioners understand and practice HP would be needed.

Implications

This study highlighted that several professionals in a top- or middle-management position in Austrian RAC, most of them with a nursing background, demonstrated a thorough conceptual understanding of HP and recognized its importance for supporting the health of the oldest old. Notwithstanding, with regard to implementing HP the study revealed that in Austrian RAC HP is currently implemented primarily in terms of single and isolated interventions and activities while the complex settings approach to HP is largely ignored. However, starting with single projects can help to shape awareness and can facilitate the initiation of further initiatives to expand HP practices. By creating organizational infrastructures to support HP efforts of professionals more complex HP initiatives, and first steps towards the development of a health-promoting RAC setting can be advanced. Concluding from this study, further educational and training programs seem essential to familiarize professionals with a broader, ecological understanding of HP that emphasizes the relation between the individual and its environment. This may stimulate professionals to start questioning how the organizational environment can be developed to allow residents to fully realize their health needs. On an organizational level, the development of departments and staff that advocate HP and ensure that it is not implemented as a marginalized activity seems crucial. The role of specialized departments and staff is then to ensure that HP is integrated within organizational standards, guidelines, and mission statement, and becomes part of the routine work across the organization. However, collaboration and exchange between staff is needed to develop and implement HP programs that address various organizational levels and therefore additional resources in terms of funding, time, and expertise are required. Finally, incentives for RAC facilities to extend their HP efforts need also to be developed within the broader context of the health and social care system in Austria. Reforms of funding systems, starting with external project funds, but looking for more systematic and sustainable solutions, might stimulate providers of RAC to invest more comprehensively in HP for residents.

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Appendix

Table 1: Participants' profile

Participant	**Gender**		**Education**		**Position**	
	Male	**Female**	**Nursing**	**Business Administration**	**Top-management**	**Middle-management**
Provider 1[*] (n=4)						
P4		x	x		x	
P8	x		x	x	x	
P6		x	x			x
P2		x	x			x
Provider 2[**] (n=2)						
P5		x	x			x
P1		x	x			x
Provider 3[**] (n=2)						
P7		x	x			x
P3		x	x		x	
Provider 4[*] (n=4)						
P12		x		x	x	
P13	x			x	x	
P9	x			x		x
P10		x	x			x
P11		x	x			x

[*]Publicly funded
[**]Privately funded